

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4413

CERTIFICATE OF DEATH

04385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Norrisville White Hall RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle RUSH Last ANDERSON				4. DATE OF DEATH Month April Day 23 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming		11. BIRTHPLACE (State or foreign country) Madonna, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Thomas Anderson				14. MOTHER'S MAIDEN NAME Bettie Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-28-2352		17. INFORMANT Mary K. Anderson White Hall, RD Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphocytic leukemia 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Oct. 1958 to 22 April 1959 , that I last saw the deceased alive on 22 April 1959 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Reginald B. Gemmill M.D.				ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED 24 April 1959			
PHYSICIAN'S NAME (Type) Reginald B. Gemmill							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/1959		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Madonna Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurt				ADDRESS Parrettville Md		24a. REC'D BY REGISTRAR APR 27 59	
				24b. REGISTRAR'S SIGNATURE Charles E. Kurt			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF CLERIC [Faint text]		NAME OF MINISTER [Faint text]	
NAME OF FUNERAL HOME [Faint text]		NAME OF BURIAL PLACE [Faint text]		NAME OF CEMETERY [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF SURVIVOR [Faint text]		NAME OF WITNESS [Faint text]	
NAME OF REGISTRAR [Faint text]		NAME OF CLERK [Faint text]		NAME OF MINISTER [Faint text]	
NAME OF FUNERAL HOME [Faint text]		NAME OF BURIAL PLACE [Faint text]		NAME OF CEMETERY [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF SURVIVOR [Faint text]		NAME OF WITNESS [Faint text]	
NAME OF REGISTRAR [Faint text]		NAME OF CLERK [Faint text]		NAME OF MINISTER [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4414

CERTIFICATE OF DEATH

04386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. LENGTH OF STAY IN 1b X Rural, Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 3		d. STREET ADDRESS R.D. 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle F. Last BALDWIN		4. DATE OF DEATH Month April Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 May 1933
9. AGE (In years last birthday) yrs. 25		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Ardy Smith		14. MOTHER'S MAIDEN NAME Irene Kenney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Raymond T. Baldwin, Havre de Grace, Md.		Address 666 Green St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Infarction & Metastasis - DUE TO 3 days - (c) Carcinoma of Uterus & Metastasis (Colostomy) 2 years - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 11, 1955 to April 11, 1959 , that I last saw the deceased alive on April 11, 1959 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 N. Union Ave. DATE SIGNED 4/11/59 ACTUAL SIGNATURE Frank Wolbert, M.D. PHYSICIAN'S NAME (Type) Frank Wolbert, M.D. Havre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/59	22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring ADDRESS Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR APR 14 '59	24b. REGISTRAR'S SIGNATURE Colbert S. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

01588

TOTALS

ANYONE

Maryland

County, Baltimore

MARYLAND

18 JAN 1933

Maryland

Frank Rogers

Residence, Baltimore, Md.

No.

DATE

TIME

Frank Rogers, M.D.

State of Maryland, Md.

Union Marine Company, Baltimore, Maryland

Frank Rogers, M.D.

Signature, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4415

CERTIFICATE OF DEATH

04387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle C. Last Billingslea		4. DATE OF DEATH Month Apr. Day 19 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1882
9. AGE (In years lost birthday) yrs. 77		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Bodt		14. MOTHER'S MAIDEN NAME Annie A. Bodt Preston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs., Dorothy Bodt, Churchville, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Extero sclerotic C-V Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 18, 1956 to April 18, 1959 , that I last saw the deceased alive on April 18, 1959 , and that death occurred at 5:24 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Horky		ADDRESS (Street, city or town, State) Churchville, Maryland.	
PHYSICIAN'S NAME (Type) J. Ralph Horky		DATE SIGNED April 18, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel		22d. LOCATION (City, town, or county) (State) Churchville, Harford, Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCone		24a. REC'D BY REGISTRAR DATE APR 23 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Kenna			

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CERTIFICATE OF DEATH

4-15

County

Maryland

Age

Sex

Chesapeake

Married

White

19

1915

1915

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4416

CERTIFICATE OF DEATH

04388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Fountain GREEN</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL Fountain GREEN</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Churchville Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>Churchville Road</u>	
3. NAME OF DECEASED (Type or print) <u>Walter T. Blevins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 28, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. W. BLEVINS</u>		14. MOTHER'S MAIDEN NAME <u>NANIE EVANS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SASSIE Richardson BLEVINS</u>		Address <u>RD # 2 BEL AIR, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-vascular Disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>April 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>59</u> , and that death occurred at <u>11:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>April 18, 1959</u> ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CRAB CREEK PRIMITIVE BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>Sparta, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u>		ADDRESS <u>W. Broadway + Williams St. BEL AIR Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 21 1959</u>		24b. REGISTRAR'S SIGNATURE <u>John L. ...</u>	

MAST AND STATE DEPARTMENT OF HEALTH—ALL MORE IS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4417

CERTIFICATE OF DEATH

04389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara</u> First <u>M</u> Middle <u>Bowman</u> Last		4. DATE OF DEATH <u>April 19</u> Month <u>19</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bush</u>		14. MOTHER'S MAIDEN NAME <u>Aliza Heimann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. William S. Bowman,</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 4, 1956</u> to <u>April 1, 1959</u> , that I last saw the deceased alive on <u>April 19, 1959</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>April 19, 1959</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

RECEIVED AND SENT DEPARTMENT OF HEALTH—BATHING 11

1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to determine what consumers want and what problems they are trying to solve. Once a need is identified, the next step is to develop a concept that addresses this need. This concept should be unique, valuable, and feasible. The third step is to create a prototype of the product. This allows the company to test the concept and make any necessary adjustments. The fourth step is to conduct a feasibility study. This involves assessing the technical, financial, and operational aspects of the product. The final step is to develop a business plan. This plan should outline the company's goals, strategies, and financial projections. It should also include a marketing plan to promote the product and a sales plan to distribute it. Once the business plan is complete, the company can begin to raise capital and launch the product.

MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>near Carsins River</u>		d. STREET ADDRESS <u>near Carsins River</u>	
3. NAME OF DECEASED (Type or print) First <u>Tolru</u> Middle <u>Rowland</u> Last <u>Bowman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5th 1889</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lubinski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs F. J. Ruppel Aberdeen Rural #2. 2nd</u>	
17. INFORMANT <u>Mrs F. J. Ruppel Aberdeen Rural #2. 2nd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <u>Coronary Occlusion</u> DUE TO (c). <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>3 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-2-</u> , 19 <u>59</u> , to <u>4-2-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2-</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, City or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>South Chapel Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Aberdeen Rural #2. 2nd</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Carrying Aberdeen, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Carling & House</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4397 CERTIFICATE OF DEATH

04391
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARTFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERC DE GRACE</u>		c. LENGTH OF STAY IN lb <u>1 1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> <u>078-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD Memorial Hospital</u>				d. STREET ADDRESS <u>Rt #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clemson</u> Middle <u>BROWN</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 9 1901</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Webster Brown</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET McMULLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-01-0849</u>		17. INFORMANT <u>Mrs Clemson Brown North East Rd 1 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>April 13 1959</u> , that I last saw the deceased alive on <u>APRIL 13</u> , 1959, and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>4/13/59</u>							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				PHYSICIAN'S NAME (Type) <u>NEIL TAYLOR</u> <u>RISING SUN Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-16-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> <u>North East Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6387

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 PM		6. PLACE OF DEATH Prison, Jackson, Mississippi	
7. CAUSE OF DEATH Homicide		8. MANNER OF DEATH Murder		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH March 10, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION None	
13. MARITAL STATUS Single		14. EDUCATION High School		15. RELIGION None	
16. SOCIAL SECURITY NUMBER [Redacted]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF PHYSICIAN [Signature]		20. SIGNATURE OF CORONER [Signature]		21. SIGNATURE OF JURY [Signature]	
22. SIGNATURE OF DISTRICT ATTORNEY [Signature]		23. SIGNATURE OF SHERIFF [Signature]		24. SIGNATURE OF CLERK [Signature]	



THIS CERTIFICATE IS REQUIRED BY THE MISSISSIPPI DEPARTMENT OF HEALTH TO BE FILED IN THE OFFICE OF THE CLERK OF THE SUPREME COURT OF THE STATE OF MISSISSIPPI. IT IS THE DUTY OF THE CLERK OF THE SUPREME COURT TO MAINTAIN A RECORD OF ALL DEATHS REPORTED TO HIM BY THE CLERKS OF THE DISTRICT COURTS OF THE STATE OF MISSISSIPPI. IT IS THE DUTY OF THE CLERK OF THE SUPREME COURT TO MAINTAIN A RECORD OF ALL DEATHS REPORTED TO HIM BY THE CLERKS OF THE DISTRICT COURTS OF THE STATE OF MISSISSIPPI.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04392

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamede Grace Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harode Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>F. S. C. Mac Carpenter</u>		4. DATE OF DEATH <u>April 18 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sparkle-Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Harode Grace Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unk.</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Peaco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>212-22-3668</u>	
17. INFORMANT <u>Ms. Madalene Williams-Harode Grace Md.</u>		Address <u>Harode Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Anteaccident auto-pedestrian type</u>			
20c. TIME OF INJURY Month, Day, Year <u>7:30 p.m. 4-18 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>—</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>Harode Grace Md.</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-18-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Kimer's Cem.</u>	22d. LOCATION (City, town, or county) <u>Harode Grace Md.</u> (State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>K. Madson Mitchell</u> ADDRESS <u>Harode Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>APR 22 '59</u>		DATE <u>APR 22 '59</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used only for burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush Chapel Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>1 Bush Chapel Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Morgan</u> Middle <u>L.</u> Last <u>Cullum</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 January 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John L. Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Alice Akers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-0519</u>	
17. INFORMANT <u>James J. Cullum</u>		Address <u>302 Pine St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Mouth</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:00</u> Hour <u>4-3</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Aberdeen Hartford Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Tarring</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '59</u>	
ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

MEDICAL CERTIFICATION

2

130

11-10-1918

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED		John J. (William)	
RESIDENCE		Alice Anna	
DATE OF DEATH		1918-02-05	
PLACE OF DEATH		New York City	
CAUSE OF DEATH		Tuberculosis	
MANNER OF DEATH		Natural	
AGE		40 years	
SEX		Male	
RACE		Caucasian	
RELIGION		Roman Catholic	
EDUCATION		High School	
OCCUPATION		Clerk	
MARRIAGE		Married	
SPOUSE		Alice Anna	
CHILDREN		None	
BIRTH DATE		1878-01-15	
BIRTH PLACE		New York City	
FATHER		John J. (William)	
MOTHER		Alice Anna	
SIGNED BY		[Signature]	
DATE		1918-02-05	
PLACE		New York City	
OFFICE		Bureau of Medical Examiners	
STATE		New York	

4399

Items 8, 9 Film G241 5-1-59 et

CERTIFICATE OF DEATH

04394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER GLE SPACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit Rural 07X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMUEL Thomas DEVONSHIRE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 21 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1880 ? 79 yrs.</u>	
9. AGE (In years lost birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Devonshire</u>				14. MOTHER'S MAIDEN NAME <u>Clara A. Found</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-20-1929</u>		17. INFORMANT Address <u>Mrs David Curry, Aberdeen, Md. Rural</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Gall-bladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Cholelithiasis (2) Hypostatic pneumonia</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 14th 1959</u> to <u>April 21st 1959</u> , that I last saw the deceased alive on <u>April 21st 1959</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford, Md.</u> DATE SIGNED <u>4/22/59</u> ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leea. Patterson & Sons</u>				ADDRESS <u>Perryville, Md.</u>		24a. REGISTRY REGISTRATION DATE <u>APR 21 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

CERTIFICATE OF DEATH

04395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bush Chapel Road</i>		d. STREET ADDRESS <i>Bush Chapel Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Keyser</i> Last <i>Ford</i>		4. DATE OF DEATH Month <i>4</i> Day <i>28</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/7/1877</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. Thornton Ford</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Stockman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mildred Cole (daughter)</i> Address <i>Alexandria, Md. 20841 Bel Air Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio sclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arthritis of Rt. Hip</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>3 Years.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>AN. 1</i> 1958, to <i>April 27, 1959</i> , that I last saw the deceased alive on <i>April 24</i> 1959, and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>André Weiss</i> M.D.		ADDRESS (Street, city or town, state) <i>114 N. Bel Air Ave, Alexandria</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ANDRE WEISS M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/1/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Spesutia Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Perryman Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Darning</i> ADDRESS <i>Alexandria, Maryland</i>		24a. REC'D BY REGISTRAR <i>APR 30 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

Items 13, 14 Film G241 4-29-59 et
4400
CERTIFICATE OF DEATH

04396
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamde de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hanford mem. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph FRANK FRANK</u>				DATE OF DEATH Month Day Year <u>April 7 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(deceased) Rose Dominski</u>				14. MOTHER'S MAIDEN NAME <u>(deceased) Frank Franczkiewicz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-09-7542</u>		17. INFORMANT Address <u>Marie Frankiewicz</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>224X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pheochromocytoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>12 hours</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 4th, 1956</u> to <u>April 7th 1959</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211N. Union Ave.</u> DATE SIGNED <u>4/7/59</u>							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weber</u>				ADDRESS <u>401 S. Chester</u>		24a. REC'D BY REGISTRAR <u>APR 14 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES H. HARRIS		Male		45		Jan 15, 1855		Maryland		Farmer	
7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SEX OF DECEASED		12. SEX OF DECEASED	
Married		Heart Disease		Home		10:30 AM		Male		Male	
13. NAME OF PHYSICIAN		14. NAME OF FUNERAL HOME		15. NAME OF BURIAL PLACE		16. DATE OF BURIAL		17. NAME OF MINISTER		18. NAME OF CHURCH	
Dr. J. H. Smith		J. H. Smith		St. Paul's Church		Jan 20, 1900		Rev. J. H. Smith		St. Paul's Church	
19. NAME OF REGISTRAR		20. NAME OF WITNESS		21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 18th day of January, 1900.

JOHN H. SMITH, REGISTRAR OF DEATHS

4401

CERTIFICATE OF DEATH

04397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. STREET ADDRESS <u>353 CARTER ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Thomas Fyle</u>				4. DATE OF DEATH Month Day Year <u>4 23 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb., 19, 1909</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RANDELL BLOODSWORTH</u>				14. MOTHER'S MAIDEN NAME <u>Anne Farnsworth DASHIELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>LEON FYLE, 353 CARTER ST, Aberdeen, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia and Acidosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> DUE TO (b) <u>Metastatic Carcinoma</u> ? DUE TO (c) <u>Squamous Cell Ca. of Cervix</u> <u>13 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 2nd, 1959</u> to <u>April 23rd, 1959</u> that I last saw the deceased alive on <u>April 23rd, 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harre-de-Grace, MD.</u> DATE SIGNED <u>4/23/59</u> ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> <u>Ind</u> PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Carrington</u>				24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberteen</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberteen</u> d. STREET ADDRESS <u>R.D. 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Alfred</u> First Middle Last 4. DATE OF DEATH <u>April 23</u> Month Day Year <u>1959</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 23 1917</u> 9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Building attendant C. & P. Co. Harford Co., Md. 2 S.A.</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>2 S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Joseph J. Gallion</u> 14. MOTHER'S MAIDEN NAME <u>Estella Hughes</u> 15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-28-3279</u> 17. INFORMANT <u>Russell Gallion R.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 SW Cerebrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4-23-59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Aberteen</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>4-23-59</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 26 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cem</u> 22d. LOCATION (City, town, or county) <u>Harford Co., MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harford Co.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> DATE <u>APR 28 '59</u> 24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4402

CERTIFICATE OF DEATH

04399

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gorsey Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margie</u> Middle <u>Holland</u> Last <u>Holland</u>				DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb., 6, 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert Holland</u>				14. MOTHER'S MAIDEN NAME <u>Estella Black</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222-10-7929</u>			
17. INFORMANT <u>Agnes A. Carney</u>				Address <u>512 Lumbard St. Wilmington, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypochromic Anemia</u> DUE TO (c) <u>Bleeding from Bladder Carcinoma of Bladder</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>5 mo</u> <u>5 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-2-59</u> to <u>4-9-59</u> , that I last saw the deceased alive on <u>4-2-59</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. Rodman</u> M.D.				ADDRESS (Street, city or town, state) <u>8 Lw St - Aberdeen, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John P. Rodman, M.D.</u>				DATE SIGNED <u>4/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery, R.D. Aberdeen, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Lanning</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

AGE
SEX
RACE

DATE OF BIRTH
PLACE OF BIRTH

EDUCATION
OCCUPATION

RELIGION
MARRIAGE

CAUSE OF DEATH
MANNER OF DEATH

DATE OF EXAMINATION
PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR

DATE OF REGISTRATION
PLACE OF REGISTRATION

DATE OF INTERMENT
PLACE OF INTERMENT

DATE OF BURIAL
PLACE OF BURIAL

DATE OF CREMATION
PLACE OF CREMATION

DATE OF REINTERMENT
PLACE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4422

CERTIFICATE OF DEATH

04400

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Hofkins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u> COLOR OR RACE <u>White</u>		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 7, 1873</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Retired dairy farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co, Md</u>	
11. BIRTH PLACE (State or foreign country) <u>V. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Hofkins</u>		14. MOTHER'S MAIDEN NAME <u>Annie Harper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Ms Isabelle Brown</u>		Address <u>Darlington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>109m</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diphtheria</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1947</u> to <u>April 20, 1959</u> that I last saw the deceased alive on <u>April 19, 1959</u> and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington</u> DATE SIGNED <u>2nd 4/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Darlington MD</u>		<u>Dudley Phillips MD</u>	
22a. BURIAL, CREMATION, or other disposal <u>buried</u>		22b. DATE THEREOF <u>April 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Am</u>		22d. LOCATION (city, town, or county) (state) <u>Harford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		23a. REC'D BY REGISTRAR <u>Arthur L. Frank</u> DATE <u>APR 28 '59</u>	
23b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1923

NAME OF DECEASED <i>John J. Hoffman</i>		SEX <i>Male</i>	
AGE <i>40</i>		DATE OF BIRTH <i>April 20, 1883</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		OCCUPATION <i>Engineer</i>	
CAUSE OF DEATH <i>Heart failure</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>April 22, 1923</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>Wm. J. Hoffman</i>		SIGNATURE OF WITNESSES <i>John J. Hoffman, Jr.</i> <i>John J. Hoffman, Sr.</i>	
SIGNATURE OF REGISTRAR <i>Wm. J. Hoffman</i>		SIGNATURE OF CLERK <i>Wm. J. Hoffman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4403

CERTIFICATE OF DEATH

04402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>HARFORD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HARRE DE GRACE</i>		c. LENGTH OF STAY IN TB <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HARFORD Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 HARRE DE GRACE</i>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>Reynolds</i> Last <i>Kiesele</i>		d. STREET ADDRESS <i>1 563 OTsego ST.</i>	
4. DATE OF DEATH Month <i>April</i> Day <i>6</i> Year <i>1959</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 20, 1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>5</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Reynolds</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Schutt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. Wm. R. Spier</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio-Renal disease</i> (c) <i>Cardio-Renal disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 1</i> , 19 <i>58</i> , to <i>April 6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4-6</i> , 19 <i>59</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. L. Lewis MD</i> M.D.		ADDRESS (Street, city or town, state) <i>Harre de Grace Md.</i> DATE SIGNED <i>April 9 1959</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>APR. 9, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de Grace Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell</i> ADDRESS <i>Harre de Grace Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 9 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Francis</i>	

4404

CERTIFICATE OF DEATH

04403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c. LENGTH OF STAY IN 1b 5 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Caroline Middle M Last Lilley				4. DATE OF DEATH Month 4 Day 23 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 10, 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Biddle				14. MOTHER'S MAIDEN NAME Rosa Brower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Carleton Robertson Address Havre de Grace, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis cerebral DUE TO Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332x				INTERVAL BETWEEN ONSET AND DEATH 5 hours 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 59 , to April 23 , 19 59 , that I last saw the deceased alive on April 23 , 19 59 , and that death occurred at 4 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Orson L. Woodrum M.D.				ADDRESS (Street, city or town, state) 407 S. Union Ave		DATE SIGNED 4/25/59	
PHYSICIAN'S NAME (Type) Joseph R. Grant							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-1959		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4405 **CERTIFICATE OF DEATH**

04404

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>		<u>07x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Alexander Jackson Little</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>February 21, 1873</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Little</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. John Little, Perryville, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Lobar Pneumonia, terminating</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Cardio-vascular Disease</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Dementia</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 9</u> , 19 <u>59</u> , to <u>April 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 19</u> , 19 <u>59</u> , and that death occurred at <u>9:00 PM</u> , from the causes end on the date stated above. SIGNATURE <u>Willard P. Hudson</u> M.D. ADDRESS <u>Forest Hill Md.</u> DATE SIGNED <u>April 21, 1959</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-23-59</u>		NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>		LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>See a Peterson</u> ADDRESS <u>Perryville, Md.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04405

4423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1		d. STREET ADDRESS R.D. #1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle M. Last LOCHARY		4. DATE OF DEATH Month April Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 August 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 10 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME E. Hall Harkins		14. MOTHER'S MAIDEN NAME Ella A. Mahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Albert Jersey Jr.		Address R.D. 1, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Disease DUE TO 6 yrs (c) Non-toxic Grits		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1956 , to April 1959 , that I last saw the deceased alive on April 8, 1959 , and that death occurred at 2:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Horky		ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED April 11, 1959	
PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/59	
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		22d. LOCATION (City, town, or county) (State) R.D., Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Tarring		24a. REC'D BY REGISTRAR APR 14 '59	
24b. REGISTRAR'S SIGNATURE Civilian S. Thane			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG241 4-28-59 et

CERTIFICATE OF DEATH

04406

4406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>621 Freedom</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Lunsford</u> Middle <u>Lunsford</u> Last		4. DATE OF DEATH <u>4/5/59</u> Month <u>4</u> Day <u>5</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/1885</u> 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Lunsford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Richard Lunsford</u> Address <u>621 Freedom Harford Chase Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Tuberculosis (Arrested)</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>April 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>59</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Republic St., Harford Chase Md.</u> DATE SIGNED <u>4/7/59</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Chase Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Ray</u> ADDRESS <u>Harford Chase</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

2000

100-100000

U.S. DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

<p>1. Name of deceased: <u>JOHN DOE</u></p>	
<p>2. Date of death: <u>10/15/1999</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Manner of death: <u>Natural</u></p>	
<p>6. Age at death: <u>65</u></p>	
<p>7. Sex: <u>Male</u></p>	
<p>8. Race: <u>White</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Occupation: <u>Teacher</u></p>	
<p>11. Education: <u>High School</u></p>	
<p>12. Date of birth: <u>10/15/1934</u></p>	
<p>13. Place of birth: <u>Baltimore, MD</u></p>	
<p>14. Date of death: <u>10/15/1999</u></p>	
<p>15. Place of death: <u>Home</u></p>	
<p>16. Cause of death: <u>Heart Disease</u></p>	
<p>17. Manner of death: <u>Natural</u></p>	
<p>18. Age at death: <u>65</u></p>	
<p>19. Sex: <u>Male</u></p>	
<p>20. Race: <u>White</u></p>	
<p>21. Marital status: <u>Married</u></p>	
<p>22. Occupation: <u>Teacher</u></p>	
<p>23. Education: <u>High School</u></p>	
<p>24. Date of birth: <u>10/15/1934</u></p>	
<p>25. Place of birth: <u>Baltimore, MD</u></p>	
<p>26. Date of death: <u>10/15/1999</u></p>	
<p>27. Place of death: <u>Home</u></p>	
<p>28. Cause of death: <u>Heart Disease</u></p>	
<p>29. Manner of death: <u>Natural</u></p>	
<p>30. Age at death: <u>65</u></p>	
<p>31. Sex: <u>Male</u></p>	
<p>32. Race: <u>White</u></p>	
<p>33. Marital status: <u>Married</u></p>	
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<p>37. Place of birth: <u>Baltimore, MD</u></p>	
<p>38. Date of death: <u>10/15/1999</u></p>	
<p>39. Place of death: <u>Home</u></p>	
<p>40. Cause of death: <u>Heart Disease</u></p>	
<p>41. Manner of death: <u>Natural</u></p>	
<p>42. Age at death: <u>65</u></p>	
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<p>44. Race: <u>White</u></p>	
<p>45. Marital status: <u>Married</u></p>	
<p>46. Occupation: <u>Teacher</u></p>	
<p>47. Education: <u>High School</u></p>	
<p>48. Date of birth: <u>10/15/1934</u></p>	
<p>49. Place of birth: <u>Baltimore, MD</u></p>	
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<p>51. Place of death: <u>Home</u></p>	
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<p>53. Manner of death: <u>Natural</u></p>	
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<p>63. Place of death: <u>Home</u></p>	
<p>64. Cause of death: <u>Heart Disease</u></p>	
<p>65. Manner of death: <u>Natural</u></p>	
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<p>207. Place of death: <u>Home</u></p>	
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<p>209. Manner of death: <u>Natural</u></p>	
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<p>212. Race: <u>White</u></p>	
<p>213. Marital status: <u>Married</u></p>	
<p>214. Occupation: <u>Teacher</u></p>	
<p>215. Education: <u>High School</u></p>	
<p>216. Date of birth: <u>10/15/1934</u></p>	
<p>217. Place of birth: <u>Baltimore, MD</u></p>	
<p>218. Date of death: <u>10/15/1999</u></p>	
<p>219. Place of death: <u>Home</u></p>	
<p>220. Cause of death: <u>Heart Disease</u></p>	
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<p>225. Marital status: <u>Married</u></p>	
<p>226. Occupation: <u>Teacher</u></p>	
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<p>237. Marital status: <u>Married</u></p>	
<p>238. Occupation: <u>Teacher</u></p>	
<p>239. Education: <u>High School</u></p>	
<p>240. Date of birth: <u>10/15/1934</u></p>	
<p>241. Place of birth: <u>Baltimore, MD</u></p>	
<p>242. Date of death: <u>10/15/1999</u></p>	
<p>243. Place of death: <u>Home</u></p>	
<p>244. Cause of death: <u>Heart Disease</u></p>	
<p>245. Manner of death: <u>Natural</u></p>	
<p>246. Age at death: <u>65</u></p>	
<p>247. Sex: <u>Male</u></p>	
<p>248. Race: <u>White</u></p>	
<p>249. Marital status: <u>Married</u></p>	
<p>250. Occupation: <u>Teacher</u></p>	
<p>251. Education: <u>High School</u></p>	
<p>252. Date of birth: <u>10/15/1934</u></p>	
<p>253. Place of birth: <u>Baltimore, MD</u></p>	
<p>254. Date of death: <u>10/15/1999</u></p>	
<p>255. Place of death: <u>Home</u></p>	
<p>256. Cause of death: <u>Heart Disease</u></p>	
<p>257. Manner of death: <u>Natural</u></p>	
<p>258. Age at death: <u>65</u></p>	
<p>259. Sex: <u>Male</u></p>	
<p>260. Race: <u>White</u></p>	
<p>261. Marital status: <u>Married</u></p>	
<p>262. Occupation: <u>Teacher</u></p>	
<p>263. Education: <u>High School</u></p>	
<p>264. Date of birth: <u>10/15/1934</u></p>	
<p>265. Place of birth: <u>Baltimore, MD</u></p>	
<p>266. Date of death: <u>10/15/1999</u></p>	
<p>267. Place of death: <u>Home</u></p>	
<p>268. Cause of death: <u>Heart Disease</u></p>	
<p>269. Manner of death: <u>Natural</u></p>	
<p>270. Age at death: <u>65</u></p>	
<p>271. Sex: <u>Male</u></p>	
<p>272. Race: <u>White</u></p>	
<p>273. Marital status: <u>Married</u></p>	
<p>274. Occupation: <u>Teacher</u></p>	
<p>275. Education: <u>High School</u></p>	
<p>276. Date of birth: <u>10/15/1934</u></p>	
<p>277. Place of birth: <u>Baltimore, MD</u></p>	
<p>278. Date of death: <u>10/15/1999</u></p>	
<p>279. Place of death: <u>Home</u></p>	
<p>280. Cause of death: <u>Heart Disease</u></p>	
<p>281. Manner of death: <u>Natural</u></p>	
<p>282. Age at death: <u>65</u></p>	
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<p>284. Race: <u>White</u></p>	
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<p>312. Date of birth: <u>10/15/1934</u></p>	
<p>313. Place of birth: <u>Baltimore, MD</u></p>	
<p>314. Date of death: <u>10/15/1999</u></p>	
<p>315. Place of death: <u>Home</u></p>	
<p>316. Cause of death: <u>Heart Disease</u></p>	
<p>317. Manner of death: <u>Natural</u></p>	
<p>318. Age at death: <u>65</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4424

CERTIFICATE OF DEATH

04407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston				c. LENGTH OF STAY IN 1b Fallston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. 2 - Box 74				d. STREET ADDRESS R. D. 2, Box 74			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NELLIE Middle RUTH Last MATTINGLY				4. DATE OF DEATH Month Apr. Day 28, Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1898	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Bagley				14. MOTHER'S MAIDEN NAME Eleanor Virginia McCauley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Mr. Donald E. Mattingly - Box 74-R D 2, Fallston			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus, mild DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs 5-6 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1956 , 19____, to April 28 , 19 59 , that I last saw the deceased alive on April 28 , 19 59 , and that death occurred at 10:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles F. Tuckner M.D. Bel Air Md. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		22d. LOCATION (City, town, or county) (State) Kingsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner & Sons - Bel Air 17th				24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4425 CERTIFICATE OF DEATH

04408

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air rural</u>		LENGTH OF STAY (in this place) <u>1 Month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jarrettsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford convalescing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>S. Grace Miller</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 6, 1874</u>	9. AGE last birthday <u>85</u> Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John E. Ensor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Chilcoat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Robert L. Miller Jarrettsville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24h.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Ch. Cerebro-Vascular Disease</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 19 59</u>, to <u>April 20, 19 59</u>, that I last saw the deceased alive on <u>April 19, 19 59</u>, and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>April 20, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEROF <u>4/22/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		LOCATION (City, town, or county) (State) <u>Jarrettsville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		REGISTRAR'S SIGNATURE <u>Charles E. Kurtz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz Jarrettsville Md.</u>			

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF SURVIVORS

16. SIGNATURE OF OTHERS

17. SIGNATURE OF CLERGY

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

23. SIGNATURE OF TOWNSHIP

24. SIGNATURE OF PARISH

25. SIGNATURE OF VILLAGE

26. SIGNATURE OF WARD

27. SIGNATURE OF DISTRICT

28. SIGNATURE OF PRESTIGE

29. SIGNATURE OF COUNTRY

30. SIGNATURE OF WORLD

31. SIGNATURE OF UNIVERSE

32. SIGNATURE OF GOD

33. SIGNATURE OF HEAVEN

34. SIGNATURE OF EARTH

35. SIGNATURE OF WATER

36. SIGNATURE OF FIRE

37. SIGNATURE OF AIR

38. SIGNATURE OF LIGHT

39. SIGNATURE OF DARKNESS

40. SIGNATURE OF SOUND

41. SIGNATURE OF SILENCE

42. SIGNATURE OF LIFE

43. SIGNATURE OF DEATH

44. SIGNATURE OF LOVE

45. SIGNATURE OF HATE

46. SIGNATURE OF HOPE

47. SIGNATURE OF DESPAIR

48. SIGNATURE OF FAITH

49. SIGNATURE OF DOUBT

50. SIGNATURE OF TRUTH

51. SIGNATURE OF LIES

52. SIGNATURE OF JUSTICE

53. SIGNATURE OF INJUSTICE

54. SIGNATURE OF MERCY

55. SIGNATURE OF CRUELTY

56. SIGNATURE OF KINDNESS

57. SIGNATURE OF RUDENESS

58. SIGNATURE OF GENTLENESS

59. SIGNATURE OF WISDOM

60. SIGNATURE OF FOOLISHNESS

61. SIGNATURE OF KNOWLEDGE

62. SIGNATURE OF IGNORANCE

63. SIGNATURE OF VIRTUE

64. SIGNATURE OF VICE

65. SIGNATURE OF GOODNESS

66. SIGNATURE OF EVILNESS

67. SIGNATURE OF BEAUTY

68. SIGNATURE OF UGLINESS

69. SIGNATURE OF CLEANLINESS

70. SIGNATURE OF DIRTYNESS

71. SIGNATURE OF ORDER

72. SIGNATURE OF DISORDER

73. SIGNATURE OF PACE

74. SIGNATURE OF WAR

75. SIGNATURE OF PEACE

76. SIGNATURE OF LOVE

77. SIGNATURE OF HATE

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264. SIGNATURE OF DISORDER

265. SIGNATURE OF PACE

266

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04409
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>18 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RD 2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Neal</i> Last <i>Moretz</i>		4. DATE OF DEATH Month <i>April</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 13-1891</i>
9. AGE (in years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>	
11. BIRTHPLACE (State or foreign country) <i>AshCo NC</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>William Moretz</i>		14. MOTHER'S MAIDEN NAME <i>Julia Trivett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>719-07-9810</i>	
17. INFORMANT <i>Mrs Ruby M Lewis</i> Address <i>ACINGDON HARTFORD CO MD BOX 258</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Cervical Vertebra</i> <i>812X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Crushing injury chest</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident auto pedestrian type</i>	
20c. TIME OF INJURY Month, Day, Year <i>4-4-59</i> Hour <i>1:25</i> a.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Road 22</i>	20f. (City or town) <i>Bel Air</i> (County) <i>Harford</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>4-4-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>April 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Big Flatts Baptist</i>	22d. LOCATION (City, town, or county) (State) <i>Fleetwood NC</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Tinto Bel Air MD</i>		24a. REC'D BY REGISTRAR DATE <i>APR 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4427

CERTIFICATE OF DEATH

04410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Henry H. Powers</u>		4. DATE OF DEATH <u>April 18</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 21, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years and month) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTH PLACE (State or foreign country) <u>Ash Co. M.C., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Andrew J. Powers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Caudill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>245-14-0840</u>	
17. INFORMANT <u>Mrs. Henry Powers</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>3-4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carlington, Md</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 3</u> , 19 <u>57</u> , to <u>4/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>59</u> , and that death occurred at <u>1304</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington Md</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips M.D.</u>		DATE SIGNED <u>4/20/59</u>	
22a. BURIAL <input type="checkbox"/> REMOVAL (Specify)	22b. DATE THROOF <u>April 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel-Air Memorial Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	
ADDRESS <u>Darlington Md</u>		DATE <u>APR 21 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

Handwritten notes and signatures are present throughout the form, including names like "H. P. ...", "M. ...", and "J. ...".

DECEASED
 Name: *H. P. ...*
 Sex: *M*
 Age: *...*
 Date of Birth: *...*
 Place of Birth: *...*

CAUSE OF DEATH
 Immediate Cause: *...*
 Underlying Cause: *...*
 Contributing Cause: *...*

DATE OF DEATH
 Date: *...*

PLACE OF DEATH
 Location: *...*

REPORTED BY
 Name: *...*
 Address: *...*

DATE OF REPORT
 Date: *...*

SIGNATURE OF REPORTER
[Signature]

DATE OF SIGNATURE
 Date: *...*

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04411

Reg. Dist. No.

4407

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 64 Mt. Royal Avenue		d. STREET ADDRESS 64 Mt. Royal Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTHA Middle M. Last RAGAN		4. DATE OF DEATH Month April Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1875
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Arrison		14. MOTHER'S MAIDEN NAME Frances McVey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Thomas Welsh, Aberdeen, Maryland		Address 64 Mt. Royal	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Occlusion DUE TO (c) Cardiac decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-11 , 19 59 , to 4-26 , 19 59 , that I last saw the deceased alive on 4-21 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 421 Congress Ave. DATE SIGNED ACTUAL SIGNATURE Gunther D. Hirsch M.D. Gunther D. Hirsch, M.D. Havre de Grace, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY North East Cemetery		22d. LOCATION (City, town, or county) (State) North East, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Tarring		24a. REC'D BY REGISTRAR DATE APR 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hirsch			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1, Gilbert Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EMORY Last RINGOLD		4. DATE OF DEATH Month April Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1864
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jane Tildon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-3309	
17. INFORMANT Annie R. Syckels		Address R.D. #1 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Fibrosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 12, 19 58 to April 4, 19 59 , that I last saw the deceased alive on April 4, 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above. George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St. DATE SIGNED			
ACTUAL SIGNATURE George T. Stansbury		PHYSICIAN'S NAME (Type) George T. Stansbury M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Julius E. Tarring		24a. REGISTERED BY REGISTRAR APR 10 1959	
ADDRESS Tarring Funeral Home		24b. REGISTRAR'S SIGNATURE Arthur L. Thane	
Aberdeen, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 15



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible fragments include:

- NAME: ...
- DATE: ...
- PLACE: ...
- CAUSE: ...
- SIGNATURE: ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4429

CERTIFICATE OF DEATH

Reg. Dist. No. U+413

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>	
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>		d. STREET ADDRESS <u>R.F.D. #1 Box 357</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. #1 Box 357</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Vincent</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Atkinson Ironing Ground, Red Star, H. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry B. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bryant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>236-05-3125</u>	
17. INFORMANT <u>Mrs. Martha Boone - Bel-Air, Md.</u>		Address <u>R.F.D. #1 Box 357</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 27</u> , 19 <u>59</u> , to <u>March 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 31</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>569 Revolution St., Havre de Grace, Md. 4/2/59</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-4-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atelia J. Bullock - Havre de Grace</u>		24a. REC'D BY REGISTRAR <u>APR 6 '59</u>	
ADDRESS <u>424</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

100% PROOF CONTENT

5. VAIN PROUD

1953

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN		ADDRESS OF REGISTRAR	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION	
FEE PAID		FEE RECEIVED		FEE REFUND	
TOTAL FEE		TOTAL RECEIVED		TOTAL REFUND	
BALANCE DUE		BALANCE RECEIVED		BALANCE REFUND	
DATE OF PAYMENT		TIME OF PAYMENT		PLACE OF PAYMENT	
SIGNATURE OF PAYOR		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
ADDRESS OF PAYOR		ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
DATE OF PAYMENT		TIME OF PAYMENT		PLACE OF PAYMENT	
FEE PAID		FEE RECEIVED		FEE REFUND	
TOTAL FEE		TOTAL RECEIVED		TOTAL REFUND	
BALANCE DUE		BALANCE RECEIVED		BALANCE REFUND	
DATE OF PAYMENT		TIME OF PAYMENT		PLACE OF PAYMENT	
SIGNATURE OF PAYOR		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
ADDRESS OF PAYOR		ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
DATE OF PAYMENT		TIME OF PAYMENT		PLACE OF PAYMENT	

4408

CERTIFICATE OF DEATH

04414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>722 S. Main St</u>				d. STREET ADDRESS <u>1 722 S. Main St</u>			
3. NAME OF DECEASED (Type or print) <u>Gladys</u> First <u>scrippens</u> Middle <u>Scrippens</u> Last				4. DATE OF DEATH <u>April</u> Month <u>13</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 1920</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>LANSING, M. CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Calvin W Sexton</u>				14. MOTHER'S MAIDEN NAME <u>Bessie E Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-16-0590</u>		17. INFORMANT <u>John Scrippens</u> Address <u>722 S. Main St Bel Air, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma R. breast with metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>59</u> , to <u>4-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>59</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u>		DATE SIGNED <u>4-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer</u> M.D.				ADDRESS <u>Bel Air, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harlington</u>		22d. LOCATION (City, town, or county) (State) <u>Harlington Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Foster</u> ADDRESS <u>Bel Air Md</u>				24a. RECEIVED BY REGISTRAR DATE <u>APR 16 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harri de Grace</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lloyd H. Shue</i>				4. DATE OF DEATH <i>April 6, 1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 5, 1900</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mech. electric</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Isreal Shue</i>				14. MOTHER'S MAIDEN NAME <i>Emma Kilbough</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <i>185-09-1878</i>		17. INFORMANT <i>Mrs. Roberta Shue</i> Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>180X Post Operative Hemorrhage</i> DUE TO <i>Right Nephrectomy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma R. Kidney</i> DUE TO (c) <i>3</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 2 1/2 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Cardiovascular Disease with Coronary Sclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>28 March, 1959</i> , to <i>6 April, 1959</i> , that I last saw the deceased alive on <i>6 April, 1959</i> , and that death occurred at <i>2:35 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. H. Sadowick</i> M.D.				ADDRESS (Street, city or town, state) <i>600 S. Union Av. Harri de Grace, Md.</i>			
DATE SIGNED <i>4/6/59</i>							
PHYSICIAN'S NAME (Type) <i>W. H. SADOWICK</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 8, 1959</i>		<i>New Freedom Cemetery</i>		<i>New Freedom, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Isaac Harkenstein</i> ADDRESS <i>New Freedom, Pa.</i>				24a. REC'D BY REGISTRAR <i>APR 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04416

4410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				d. STREET ADDRESS 54 N. MAIN			
3. NAME OF DECEASED (Type or print) Baby Boy First Slayman Middle Slayman Last				4. DATE OF DEATH April 3 1959 Month April Day 3 Year 1959			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-59	
9. AGE (If years lost birthday) 2 yrs.		IF UNDER 1 YEAR 2 Months 4 Days 43 Mins.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Richard Slayman				14. MOTHER'S MAIDEN NAME HELEN ELIZABETH SHOUEMAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT mother Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXTREME PREMATURITY (Birth wt 1#11g) DUE TO (c) PARTIAL SEPARATION OF PLACENTA (PREMATURITY)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-4-59 , 19 59 , to 4-4-59 , that I last saw the deceased alive on 4-4-59 , 19 59 , and that death occurred at 11:10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-1959		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Colora, md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Perryville, md.				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

2071222XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4430 CERTIFICATE OF DEATH

04417

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITEFORD</u>	LENGTH OF STAY (in this place) <u>15 YRS.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITEFORD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Catherine Elizabeth Stewart</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 12 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>18 April 1879</u>
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>KONKS, Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HENRY BROWNSBERGER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA GOLDFUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>FRANCIS H. STEWART, WHITEFORD, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>Diabetes mellitus - & uremia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yr +</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC cardiovascular</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct</u>, 19<u>57</u>, to <u>11 Apr</u>, 19<u>59</u>, that I last saw the deceased alive on <u>11 Apr</u>, 19<u>59</u>, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Edmund W. Whiteford Jr. M.D.</u>		ADDRESS (Street, city, town, state) <u>Whiteford Maryland</u>	
DATE SIGNED <u>4/12/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-16-59</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		LOCATION (City, town, or county) <u>PLESVILLE, MD.</u>	
24. REC'D BY REGISTRAR <u>APR 14 '59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Harkins, Delta, Pa.</u>	

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Married

Occupation

Signature

NOTICE

ALL DEATHS MUST BE REPORTED TO THE HEALTH DEPARTMENT WITHIN 24 HOURS OF THE DEATH. A FEE OF \$1.00 WILL BE CHARGED FOR EACH DEATH REPORT. THE HEALTH DEPARTMENT WILL ISSUE A CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON RESPONSIBLE FOR THE BURIAL OF THE DECEASED. THE CERTIFICATE OF DEATH IS A LEGAL DOCUMENT AND MUST BE KEPT FOR AT LEAST 10 YEARS. IT IS THE DUTY OF THE REPORTER TO FURNISH THE CORRECT INFORMATION AND TO SIGN THE CERTIFICATE OF DEATH. IF THE REPORTER IS A PHYSICIAN, HE OR SHE MUST SIGN THE CERTIFICATE OF DEATH. IF THE REPORTER IS A CLERGYMAN, A JUDGE, A JUSTICE OF THE PEACE, A NOTARY PUBLIC, OR A MEMBER OF THE BOARD OF HEALTH, HE OR SHE MUST SIGN THE CERTIFICATE OF DEATH. IF THE REPORTER IS A MEMBER OF THE BOARD OF HEALTH, HE OR SHE MUST SIGN THE CERTIFICATE OF DEATH. IF THE REPORTER IS A MEMBER OF THE BOARD OF HEALTH, HE OR SHE MUST SIGN THE CERTIFICATE OF DEATH.

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Signature of Physician		Signature of Registrar	
Signature of Next of Kin		Signature of Burial Officer	
Signature of Coroner		Signature of Medical Examiner	
Signature of Health Officer		Signature of Board of Health	
Signature of Mayor		Signature of City Council	
Signature of State Board of Health		Signature of State Department of Health	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4411

CERTIFICATE OF DEATH

04418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 133 Thomas Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Coza Middle Lee Last Suite			4. DATE OF DEATH Month April Day 16 Year 19 59				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1888		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Green Pilkins				14. MOTHER'S MAIDEN NAME Carolyn Casey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-20-5596		17. INFORMANT John A. Suite, Bel Air, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro-vascular Disease DUE TO (c) ??						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 1959 , to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 10:00a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson		M.D.		ADDRESS (Street, city or town, state) Forest Hill, Md.		DATE SIGNED 4-17-59	
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Church		22d. LOCATION (City, town, or county) (State) Rt. #2, Bel Air, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Suite				ADDRESS Bel Air, Md.		24a. REC'D BY REGISTRAR DATE APR 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thoma			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>	c. LENGTH OF STAY IN 1b <u>55YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X (RURAL) ROCKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	f. STREET ADDRESS <u>SHARON Rd</u>
3. NAME OF DECEASED (Type or print) First <u>CHARLS</u> Middle <u>AMOS</u> Last <u>SWEETING</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>ROCKS, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. SWEETING</u>		14. MOTHER'S MAIDEN NAME <u>EUGENIA AMOS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILSON SWEETING</u>		Address <u>ROCKS, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND ENTERING HEAD</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>THRU MOUTH UNDER TONGUE</u> DUE TO (c) <u>SUICIDE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>SUICIDE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>APRIL 24 1959</u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>ROCKS, HARFORD, MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, MD.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>APRIL 26, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APR 28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Waters</u>		22d. LOCATION (City, town, or county) (State) <u>Carrollton Heights, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin J. Kurtz</u>		ADDRESS <u>1400 E. Pratt St.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orin S. King</u>	

4431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF EXAMINER: _____

10. DATE: _____

11. TIME: _____

12. PLACE: _____

13. SIGNATURE OF WITNESS: _____

14. DATE: _____

15. TIME: _____

16. PLACE: _____

17. SIGNATURE OF SECOND WITNESS: _____

18. DATE: _____

19. TIME: _____

20. PLACE: _____

21. SIGNATURE OF THIRD WITNESS: _____

22. DATE: _____

23. TIME: _____

24. PLACE: _____

25. SIGNATURE OF FOURTH WITNESS: _____

26. DATE: _____

27. TIME: _____

28. PLACE: _____

29. SIGNATURE OF FIFTH WITNESS: _____

30. DATE: _____

31. TIME: _____

32. PLACE: _____

33. SIGNATURE OF SIXTH WITNESS: _____

34. DATE: _____

35. TIME: _____

36. PLACE: _____

37. SIGNATURE OF SEVENTH WITNESS: _____

38. DATE: _____

39. TIME: _____

40. PLACE: _____

41. SIGNATURE OF EIGHTH WITNESS: _____

42. DATE: _____

43. TIME: _____

44. PLACE: _____

45. SIGNATURE OF NINTH WITNESS: _____

46. DATE: _____

47. TIME: _____

48. PLACE: _____

49. SIGNATURE OF TENTH WITNESS: _____

50. DATE: _____

51. TIME: _____

52. PLACE: _____

53. SIGNATURE OF ELEVENTH WITNESS: _____

54. DATE: _____

55. TIME: _____

56. PLACE: _____

57. SIGNATURE OF TWELFTH WITNESS: _____

58. DATE: _____

59. TIME: _____

60. PLACE: _____

61. SIGNATURE OF THIRTEENTH WITNESS: _____

62. DATE: _____

63. TIME: _____

64. PLACE: _____

65. SIGNATURE OF FOURTEENTH WITNESS: _____

66. DATE: _____

67. TIME: _____

68. PLACE: _____

69. SIGNATURE OF FIFTEENTH WITNESS: _____

70. DATE: _____

71. TIME: _____

72. PLACE: _____

73. SIGNATURE OF SIXTEENTH WITNESS: _____

74. DATE: _____

75. TIME: _____

76. PLACE: _____

77. SIGNATURE OF SEVENTEENTH WITNESS: _____

78. DATE: _____

79. TIME: _____

80. PLACE: _____

81. SIGNATURE OF EIGHTEENTH WITNESS: _____

82. DATE: _____

83. TIME: _____

84. PLACE: _____

85. SIGNATURE OF NINETEENTH WITNESS: _____

86. DATE: _____

87. TIME: _____

88. PLACE: _____

89. SIGNATURE OF TWENTIETH WITNESS: _____

90. DATE: _____

91. TIME: _____

92. PLACE: _____

93. SIGNATURE OF TWENTY-FIRST WITNESS: _____

94. DATE: _____

95. TIME: _____

96. PLACE: _____

97. SIGNATURE OF TWENTY-SECOND WITNESS: _____

98. DATE: _____

99. TIME: _____

100. PLACE: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04420

Reg. Dist. No.

4432

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	c. LENGTH OF STAY IN 1b <u>2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Otter Point Road</u>		d. STREET ADDRESS <u>Otter Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>W. H. Tefke</u>		4. DATE OF DEATH <u>April 22 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-76</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Moore</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hurley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John L. Tefke</u>		Address <u>Box 132 Otter Pt Rd. Abingdon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Stemmers Run, Balto. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4433 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Tiller Last Tiller		4. DATE OF DEATH Month April , Day 1 , Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1897
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Dave Tiller		14. MOTHER'S MAIDEN NAME Mary Barton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 228-09-8132	
17. INFORMANT Jettie B. Tiller,		Address Joppa, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Bladder (Keratinizing type) 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 25, 1952 to 4/1, 1959 , that I last saw the deceased alive on 4/1, 1959 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson M.D.		DATE SIGNED April 1, 1959	
PHYSICIAN'S NAME (Type) Clifford F. Hudson		Fork, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Apr. 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Gent Funeral Home		22d. LOCATION (City, town, or county) (State) Honaker, Russell Co., Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCombs		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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David J. Fox

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MATT BILTON

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Donnerstag, 1. April 1948

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4412

CERTIFICATE OF DEATH

04422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW MEXICO b. COUNTY LEA 68X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		c. LENGTH OF STAY IN 1b 1 WEEK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 NO. KELLY AVE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TATUM (RURAL) Box 123	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 12 MILES EAST OF TATUM ON Rt 380	
3. NAME OF DECEASED (Type or print) First EUGENE Middle (NONE) Last WATKINS		4. DATE OF DEATH Month APRIL Day 30 Year 19 59	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 27, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RANCHER		10b. KIND OF BUSINESS OR INDUSTRY CATTLE	
11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SIDNEY DANIEL WATKINS		14. MOTHER'S MAIDEN NAME FLORENCE CASSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 525-48-3485	
17. INFORMANT (SON) WAYNE WATKINS		Address BEL AIR, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CARDIAC INSUFFICIENCY DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 MIN OVER 4 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 27, 1959 to APRIL 30, 1959 , that I last saw the deceased alive on APRIL 30, 1959 , and that death occurred at 11:58 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 307 HICKORY DATE SIGNED APRIL 30, 1959			
ACTUAL SIGNATURE Philip W. Heuman M.D.		PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN BEL AIR, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3/59	
22c. NAME OF CEMETERY OR CREMATORY Chandler Ck/9.		22d. LOCATION (City, town, or county) (State) Chandler Ck/9. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster ADDRESS West Broadway + Williams St. Bel Air, Maryland		24a. REC'D BY REGISTRAR Arthur L. Evans DATE MAY 4 '59	

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4434 CERTIFICATE OF DEATH

04423
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kalmia-Bel Air R.D. Life</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air, R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Forge Hill Rd/</u>				STREET ADDRESS (If rural give location) <u>Forge Hill RD.</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna</u> (First) <u>Mae</u> (Middle) <u>Williams</u> (Last)				4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>23</u> , (Year) <u>19</u> <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 16, 1926</u>		9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Druescella Wilmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-8919</u>		17. INFORMANT & ADDRESS <u>Mrs. Emma V. Brooks, Box 242A</u> <u>R.D.#1, Bel Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
241X IMMEDIATE CAUSE (A) <u>Bronchial asthma</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>April 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>59</u> , and that death occurred at <u>10:40pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>April 24, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 59</u>		NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		LOCATION (City, town, or county) (State) <u>Kalmia, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>APR 27 '59</u>		REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway and Williams St.,</u> <u>Bel Air, Maryland</u>			

CERTIFICATE OF DEATH

File No. 12345

1. Name of deceased: JOHN DOE

2. Sex: Male

3. Race: White

4. Age: 45

5. Date of birth: Jan 1, 1900

6. Place of birth: Baltimore, Md.

7. Usual residence: 123 Main St., Baltimore, Md.

8. Date of death: Dec 15, 1945

9. Time of death: 10:30 AM

10. Cause of death: Heart disease

11. Immediate cause: Myocardial infarction

12. Underlying cause: Arteriosclerosis

13. Contributing cause: None

14. Manner of death: Natural

15. Signature of physician: [Signature]

16. Signature of registrar: [Signature]

17. Date of registration: Dec 16, 1945

18. Place of registration: Baltimore, Md.

19. Name of registrar: [Name]

20. Title of registrar: Registrar

21. Address of registrar: 123 Main St., Baltimore, Md.

22. Telephone number: 123-4567

23. Name of hospital: None

24. Name of doctor: None

25. Name of nurse: None

26. Name of attendant: None

27. Name of undertaker: None

28. Name of funeral home: None

29. Name of cemetery: None

30. Name of burial place: None

31. Name of interment place: None

32. Name of crematorium: None

33. Name of funeral home: None

34. Name of undertaker: None

35. Name of attendant: None

36. Name of nurse: None

37. Name of doctor: None

38. Name of hospital: None

39. Name of place of death: None

40. Name of place of burial: None

41. Name of place of interment: None

42. Name of place of cremation: None

43. Name of place of funeral: None

44. Name of place of burial: None

45. Name of place of interment: None

46. Name of place of cremation: None

47. Name of place of funeral: None

48. Name of place of burial: None

49. Name of place of interment: None

50. Name of place of cremation: None

51. Name of place of funeral: None

52. Name of place of burial: None

53. Name of place of interment: None

54. Name of place of cremation: None

55. Name of place of funeral: None

56. Name of place of burial: None

57. Name of place of interment: None

58. Name of place of cremation: None

59. Name of place of funeral: None

60. Name of place of burial: None

61. Name of place of interment: None

62. Name of place of cremation: None

63. Name of place of funeral: None

64. Name of place of burial: None

65. Name of place of interment: None

66. Name of place of cremation: None

67. Name of place of funeral: None

68. Name of place of burial: None

69. Name of place of interment: None

70. Name of place of cremation: None

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73. Name of place of interment: None

74. Name of place of cremation: None

75. Name of place of funeral: None

76. Name of place of burial: None

77. Name of place of interment: None

78. Name of place of cremation: None

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80. Name of place of burial: None

81. Name of place of interment: None

82. Name of place of cremation: None

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84. Name of place of burial: None

85. Name of place of interment: None

86. Name of place of cremation: None

87. Name of place of funeral: None

88. Name of place of burial: None

89. Name of place of interment: None

90. Name of place of cremation: None

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92. Name of place of burial: None

93. Name of place of interment: None

94. Name of place of cremation: None

95. Name of place of funeral: None

96. Name of place of burial: None

97. Name of place of interment: None

98. Name of place of cremation: None

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101. Name of place of interment: None

102. Name of place of cremation: None

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104. Name of place of burial: None

105. Name of place of interment: None

106. Name of place of cremation: None

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109. Name of place of interment: None

110. Name of place of cremation: None

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112. Name of place of burial: None

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114. Name of place of cremation: None

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117. Name of place of interment: None

118. Name of place of cremation: None

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125. Name of place of interment: None

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129. Name of place of interment: None

130. Name of place of cremation: None

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133. Name of place of interment: None

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189. Name of place of interment: None

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192. Name of place of burial: None

193. Name of place of interment: None

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216. Name of place of burial: None

217. Name of place of interment: None

218. Name of place of cremation: None

219. Name of place of funeral: None

220. Name of place of burial: None

221. Name of place of interment: None

222. Name of place of cremation: None

223. Name of place of funeral: None

224. Name of place of burial: None

225. Name of place of interment: None

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4435

CERTIFICATE OF DEATH

14424

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall R.D.</u>		c. LENGTH OF STAY IN 1b <u>80 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Thomas</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29-1876</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Atmos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Jenora G Williams</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis Generalized,</u> DUE TO (c) <u>15 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1950</u> , to <u>April 25, 1959</u> , that I last saw the deceased alive on <u>April 25, 1959</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stewartstown, Pa</u> DATE SIGNED <u>4-25-59</u>			
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u> <u>Stewartstown, Pa</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin G. Gentry, Jarrettsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 15, 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. COLOR <i>White</i>	
13. EDUCATION <i>High School</i>		14. RELIGION <i>Methodist</i>		15. PREVIOUS ILLNESS <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
19. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		20. SIGNATURE OF CLERK <i>John A. Smith</i>		21. SIGNATURE OF JURY <i>John A. Smith</i>	
22. SIGNATURE OF JURY <i>John A. Smith</i>		23. SIGNATURE OF JURY <i>John A. Smith</i>		24. SIGNATURE OF JURY <i>John A. Smith</i>	
25. SIGNATURE OF JURY <i>John A. Smith</i>		26. SIGNATURE OF JURY <i>John A. Smith</i>		27. SIGNATURE OF JURY <i>John A. Smith</i>	
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